Ministry of Human Services' Response to the RJ Fatality Inquiry Report

February 2014

Alberta
Human Services

Background

The Ministry of Human Services has carefully reviewed the fatality inquiry report released on February 28, 2014 regarding the death of RJ on November 11, 2010.

The inquiry found that this death was due to cardiac arrest and anoxic brain injury, resulting from traumatic injury to the cervical spine following a fall down a flight of stairs in his home. The manner of death was accidental. RJ was an adult with a developmental and physical disability, who was non-verbal and used a wheelchair to get around. He was a ward of the Public Guardian of Alberta from 1997 until his death. RJ was living in a group home staffed by an agency funded by Persons with Developmental Disabilities (PDD) program at the time of his death.

The fatality inquiry report made seven recommendations for preventing similar deaths. In addition to the fatality inquiry review, an internal investigation was conducted by the Central Region PDD Community Board in November 2010 and made eight recommendations for the service provider. The service provider has implemented all the recommendations.

General Response

The Ministry of Human Services is committed to the safety and security of all individuals accessing Government of Alberta programs and services. PDD is dedicated to continuous improvement of services and will continue to work in partnership with service providers and community to promote positive outcomes and a high quality of life for the individuals they serve.

PDD Communication with Individuals, Families and Guardians

In 2013, the PDD Safety Standard Regulation was implemented, in addition to the *Supported Living Accommodations Licencing Act*, to ensure the physical accommodation of the residences where PDD-funded individuals live is safe and meets high standards. Required Standards fall in the areas of:

- Safety Requirements
- Maintenance requirements
- Medication Assistance of Medication Reminders
- Water Temperature
- Concerns and Complaints
- Safety and Security of Adults with Developmental Disabilities
- Compliance with Various Codes and Bylaws

PDD has implemented this regulation which requires a thorough inspection of group homes where individuals who receive PDD-funded services live. Inspections are completed by Alberta Health staff of the Standards, Licensing and Compliance Branch, Environmental Public Health Officers under Alberta Health Services, local Safety Codes Officers and municipal Development Officers. The PDD Safety Standards program policy and the PDD Safety Standard Regulation are posted on the PDD public website.

Comprehensive information regarding safeguards and standards for PDD-funded services is available online at http://humanservices.alberta.ca/PDD-online/. The link includes specific information for individuals, families and guardians on risk assessment/management, abuse prevention and response, as well as the PDD Safety Standards Regulation which all focus on contributing to the safety of individuals living in PDD-funded settings.

Brochures for Individuals and families have been developed and are available at:

- http://humanservices.alberta.ca/documents/PDD/pdd-safety-standards-family-pamphlet.pdf

- http://humanservices.alberta.ca/documents/PDD/pdd-safety-standards-individuals-pamphlet.pdf

PDD has also developed and is implementing provincial policy pertaining to support for people with complex service needs. This policy requires PDD staff and funded service providers, in collaboration with the individual and their family, to complete a risk assessment for people identified as having complex service needs and where appropriate, develop a risk mitigation plan to address the specific needs of that individual. Complex needs policy is posted on the PDD public website.

PDD Communication with Service Providers

All PDD-funded service providers that provide 24-hour support in a home where more than four individuals with developmental disabilities live must comply with the *Supported Living Accommodations Licencing Act*. Service providers funded by PDD to provide 24-hour support for up to three Individuals within a home are required to comply with the new PDD Safety Standards. PDD continues to provide information, in-service training, advice and support to service providers to ensure they have the information they need to implement the new standards.

All PDD-funded service providers are required as a condition of funding, to undergo and pass an accreditation survey by an approved accrediting body at least once every three years. Amongst a number of industry standards, this accreditation process ensures that service providers have in place appropriate policy and practice as it pertains to the use of planned and unplanned restrictive procedures.

Public Fatality Inquiry

A Public Fatality Inquiry hearing was held in Red Deer on November 27-28, 2013 to determine the cause and manner of death. The Fatality Inquiry Report concluded that RJ's death was accidental and the presiding Judge indicated that "In light of the changes made by the service provider to policies, practices and group home facilities, it was found that adequate care and services are available at the service provider group homes for persons suffering from mental, developmental and physical disabilities of the nature and to the degree that afflicted RJ."

The Judge made the following recommendations for preventing similar deaths:

(1) Close circuit television (CCTV) cameras should be installed and should operate continually to monitor doors leading to basement stairways in group homes where staff occupying group home offices do not have a direct and unobstructed view of those doors. A CCTV screen should be located in the main floor staff office and that screen should be activated whenever group home employees occupy those offices.

(2) An auditory alarm system should be installed in group homes to notify staff if a basement door is left open or ajar, excepting group homes housing client(s) that suffer from Autism Spectrum Disorder or other disorders that render auditory alarms unacceptable. In those group homes a visual alarm system incorporating flashing warning lights at strategic locations in the group home should be installed.

(3) A policy requiring that staff check to ensure that basement doors are locked at the start and at the end of each work shift and at regular intervals during the course of each work shift should be instituted.

(4) Records of group home staff attendance at Restrictive Practice training sessions should be created and maintained.

(5) A policy requiring regular and timely maintenance of the self-locking basement doors should be instituted and records of that maintenance should be created and maintained.

(6) There should be no throw rugs or other obstructions placed on the floors in proximity to self-locking basement doors.

(7) If not already established, a policy should be instituted requiring a risk assessment specific to each group home resident be completed, particularly when a group home resident is moved from one group home into a different group home.

Fatality Inquiry Recommendations

The recommendations of the Fatality Inquiry report are currently being carefully reviewed against current PDD policy and practice and where modifications and/or changes need to occur, PDD will take steps to ensure that individuals with disabilities are safe within their home and that this kind of accident does not occur in the future.

Recommendation # 1: Close Circuit Television

Close circuit television (CCTV) cameras should be installed and should operate continually to monitor doors leading to basement stairways in group homes where staff occupying group home offices do not have a direct and unobstructed view of those doors. A CCTV screen should be located in the main floor staff office and that screen should be activated whenever group home employees occupy those offices.

Recommendation # 2: Auditory Alarm System

An auditory alarm system should be installed in group homes to notify staff if a basement door is left open or ajar, excepting group homes housing client(s) that suffer from Autism Spectrum Disorder or other disorders that render auditory alarms unacceptable. In those group homes a visual alarm system incorporating flashing warning lights at strategic locations in the group home should be installed.

Ministry Response for Recommendation #1 & 2:

The Ministry will support service providers in ensuring where there are circumstances in which basement stairways or doors pose a potential risk to an individual receiving PDD-funded service, environmental alarm systems are in place. The Ministry will work with service providers and Government partners to determine the nature and scope of the impact of these recommendations. The Ministry will identify residences in which the above recommendations would apply and implement the appropriate safety mechanism.

Recommendation # 4: Restrictive Practice Training

Records of group home staff attendance at Restrictive Practice training sessions should be created and maintained.

Ministry Response:

The Ministry believes that all staff who support individuals with developmental disabilities should be supported to have the appropriate orientation and training necessary to provide quality services to the people they serve. The Ministry will work with the Alberta Council of Disability Services (ACDS) to provide opportunities for Proactive Behavioural training (which addresses the appropriate use of restrictive practices) sessions throughout the province on an ongoing basis.

Recommendation # 3: Basement Doors

A policy requiring that staff check to ensure that basement doors are locked at the start and at the end of each work shift and at regular intervals during the course of each work shift should be instituted.

Recommendation # 5: Maintenance and Records

A policy requiring regular and timely maintenance of the self-locking basement doors should be instituted and records of that maintenance should be created and maintained.

Recommendation # 6: Obstructions

There should be no throw rugs or other obstructions placed on the floors in proximity to self-locking basement doors.

Ministry Response for Recommendation #3, 5 & 6:

The PDD Safety Standard Regulation was implemented by PDD to ensure the physical accommodation of the residences where PDD-funded individuals live is safe and meets high standards, similar to that of the *Supported Living Accommodations Licencing Act*.

Once the inspection has occurred, the service provider will receive a certificate with or without conditions for each residence they provide supports in;

- If a certificate without conditions is given, there is no further follow up required at that point as the Safety Standards have been met;

- If a certificate with conditions is given, the Inspector will create an action plan in collaboration with the service provider to achieve compliance to the safety standards.
- Once the timeline for completing the action plan has been reached, the Inspector will follow-up with the service provider. A follow up visit to the residence may or may not take place specific to the actions identified in the action plan. If the conditions have been met, a full certificate will be issued. If the conditions have not been met, the inspector may issue a new action plan with a new timeline and a certificate with conditions.

Recommendation	PDD Safety Standard
Recommendation # 3: Basement Doors	Standard 7
Recommendation # 5: Maintenance and Records	Standard 1 and Standard 2
Recommendation # 6: Obstructions	Standard 1

As well, if the Standards and Licensing Branch find a concern that is outside of the scope of the PDD Safety Standard Regulation or Supported Living Accommodation Licensing Act they will refer these concerns to other authorities who have jurisdictional responsibility (i.e. Environment Health, Fire Inspections).

The PDD Safety Standards complement existing monitoring and accountability mechanisms used by the PDD program such as the Service Provider Agreement, Creating Excellence Together accreditation standards and the Abuse Prevention and Reporting Protocol.

Recommendation # 7: Environmental Risk Assessment

If not already established, a policy should be instituted requiring a risk assessment specific to each group home resident be completed, particularly when a group home resident is moved from one group home into a different group home.

Ministry Response:

PDD Policy states that once a person begins to receive services an individual support plan will be developed. The individual support plan identifies measures/supports that are needed to improve the individuals' quality of life – including in the areas of health and safety. For individuals with mobility issues, this will include environmental safety mitigation strategies.

When a person moves to a new service provider, the expectation is individual support plans are shared with the new service provider

Central Region PDD Internal Investigation

An internal investigation was conducted by the Central Region PDD Community Board in November 2010 and made the following recommendations:

(a) The service provider needs to develop and implement a formal risk assessment process that identifies potential risk and proved risk mitigation strategies;

(b) The service provider should undertake a review of any policies or practices that relate to the use of restrictive procedures or practices;

(c) The service provider should develop a system to make sure that all staff working in a home are aware of and understand any restrictive procedures and practices that are in place;

(d) The service provider should ensure that staff sign off on Restrictive Practices and Procedures, acknowledging that they have read them and understand them;

(e) Restrictive Practices and Procedures should be reviewed and updated as required before a client is moved from one group home to a different group home;

(f) The service provider should ensure regular and frequent monitoring in order to attempt to determine the effectiveness of each Restrictive Practice and in order to allow staff to report failures to consistently follow Restrictive Practices;

(g) The service provider should consider installing automatic locking doors, particularly when a person receiving services is either directly or indirectly responsible to lock a door; and

(h) The doors in the service provider's group homes should be monitored to ensure they are fully closed.

The service provider agreed with and fully implemented these recommendations.

Conclusion

The Ministry of Human Services is committed to the safety and well-being of persons with disabilities. We strive for continuous improvement of the disability services system across the province, for all Albertans.

Providing Albertans with disabilities with the resources and supports they need to ensure they have opportunities to fully participate and be safe in their homes and communities is a Ministry priority. By working with government and community partners to address the safety and well-being of vulnerable Albertans, regardless of where they live, the Ministry is taking action to ensure that individuals with disabilities have a high quality of life and receive the quality supports they deserve.